FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020495

Facility Name: Brother James Court

Address: 2500 St. James Road (Number) Springfield (City) 62707 (Zip Code)

County: Sangamon

Telephone Number: (217)544-4876 **Fax #** (217) 544-4877

IDPA ID Number: 43/1588535004

Date of Initial License for Current Owners: October 1, 1975

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Daniel J. Call **Telephone Number:** (217)793-3363

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/00 to 06/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Brother David Sarnecki
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Daniel J. Call, CPA, Partner
(Firm Name & Address) Sikich Gardner & Co, LLP, 1000 Churchill Road, Springfield, IL 62702
(Telephone) (217)793-3363 Fax # (217)793-3016

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	93	Intermediate/DD	93	33,945	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	32,391	642		33,033	12
13	DD 16 OR LESS					13
14	TOTALS	32,391	642		33,033	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.31%

D. How many bed-hold days during this year were paid by Public Aid?
1,554 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30 Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Brother James Court # 0020495 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	271,467	23,048	720	295,235		295,235		295,235			1
2	Food Purchase		158,443		158,443		158,443		158,443			2
3	Housekeeping	51,578	14,669	3,247	69,494		69,494		69,494			3
4	Laundry	51,003	7,095		58,098		58,098		58,098			4
5	Heat and Other Utilities			113,712	113,712		113,712		113,712			5
6	Maintenance	78,114		110,976	189,090		189,090		189,090			6
7	Other (specify):*											7
8	**TOTAL General Services**	452,162	203,255	228,655	884,072		884,072		884,072			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	898,411	33,499	8,692	940,602		940,602		940,602			10
10a	Therapy			117	117		117		117			10a
11	Activities	7,578			7,578		7,578		7,578			11
12	Social Services	114,430		17,082	131,512		131,512		131,512			12
13	Nurse Aide Training											13
14	Program Transportation			10,874	10,874		10,874		10,874			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,020,419	33,499	39,165	1,093,083		1,093,083		1,093,083			16
	C. General Administration											
17	Administrative	68,560		820	69,380		69,380		69,380			17
18	Directors Fees											18
19	Professional Services			38,658	38,658		38,658		38,658			19
20	Dues, Fees, Subscriptions & Promotions			8,575	8,575		8,575		8,575			20
21	Clerical & General Office Expenses	140,000	21,061	51,956	213,017		213,017		213,017			21
22	Employee Benefits & Payroll Taxes			281,747	281,747		281,747		281,747			22
23	Inservice Training & Education			4,427	4,427		4,427		4,427			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			35,316	35,316		35,316		35,316			26
27	Other (specify):*											27
28	**TOTAL General Administration**	208,560	21,061	421,499	651,120		651,120		651,120			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,681,141	257,815	689,319	2,628,275		2,628,275		2,628,275			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Brother James Court #0020495 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			193,154	193,154		193,154	140,575	333,729			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			270,000	270,000		270,000	(270,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			463,154	463,154		463,154	(129,425)	333,729			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			186,604	186,604		186,604		186,604			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			186,604	186,604		186,604		186,604			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,681,141	257,815	1,339,077	3,278,033		3,278,033	(129,425)	3,148,608			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(129,425)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (129,425)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (129,425)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ NONE		47

Brother James Court

ID# 0020495

Report Period Beginning: 07/01/00

Ending: 06/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brother James Court # 0020495 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	140,575	0	0	0	0	0	0	0	0	0	140,575	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(270,000)	0	0	0	0	0	0	0	0	0	(270,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(129,425)	0	0	0	0	0	0	0	0	0	(129,425)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	(129,425)	0	0	0	0	0	0	0	0	0	(129,425)	45

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A	N/A	N/A		Franciscan Brothers of the Holy Cross	Springfield	Religious Order
				Springfield Developmental Center	Springfield	Day Training Prog
				Weber Care Corp.	Springfield	Community Living facility

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	$ 270,000	Franciscan Brothers of the Holy Cross	100.00%	$	$ (270,000)	1
2	V	30	Depreciation		Franciscan Brothers of the Holy Cross	100.00%	140,575	140,575	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 270,000			$ 140,575	$ * (129,425)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Brother Raphael Kreikemeier	Food Service	Head Cook	none	none	60	100.00	Salary	$ 65,520	1,1	1
2		Supervisor									2
3	Brother Luke Morin	Resident Services	Coordinates	none	none	60	100.00	Salary	65,520	10,1	3
4		Coordinator	Resident Services								4
5	Brother Gerald Voycheck	Social Services	Social Worker/	none	none	60	100.00	Salary	68,560	17,1	5
6			Administrator								6
7	Brother John Francis Tyrrell	Administrator	Administrator	none	none	60	100.00	Salary	19,810		7
8											8
9	NOTE:										9
10	These are the only board members of Brother James Court Association. All										10
11	Brothers are employed by Brother James Court in the positions described										11
12	above. These board members have no ownership interest in any organizations.										12
13								TOTAL	$ 219,410		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	N/A					$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brother James Court COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0020495

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,477 B. General Construction Type: Exterior Brick/Stone Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ Not Available	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1975	1975	$ 1,003,250	$	30	$ 33,442	$ 33,442	$ 895,209	4
5			1996	1996	1,251,493		30	41,716	41,716	208,582	5
6			1997	1997	1,256,490		30	41,883	41,883	151,239	6
7											7
8											8
	Improvement Type**										
9	New Wing - Heating and air conditioning			1997	18,883		30	629	629	2,570	9
10	Repave parking lot			1986	42,236		10			42,236	10
11	Painting/decorating			1979	2,591		5			2,591	11
12	BJC -Building improvements			1980	16,233		11			16,233	12
13	BJC -Building improvements			1984	21,419		10			21,419	13
14	BJC - Remodeling			1987	69,555		10			69,555	14
15	BJC - Water line			1987	14,120		20	706	706	9,178	15
16	Insulation			1991	9,175		15	612	612	6,066	16
17	Electrical repair			1991	613		10	61	61	593	17
18	Boiler room remodeling			1992	15,089		20	754	754	6,950	18
19	Tank removal			1992	8,500		10	850	850	8,075	19
20	Dishwashing room sewer			1992	10,680		20	534	534	5,073	20
21	BJC - Steam line			1985	14,479		10			14,479	21
22	BJC - Building improvements			1975	19,600		24			19,600	22
23	BJC - Dining area remodeling			1976	34,951		10			34,951	23
24	BJC - Sidewalk/patio			1976	3,545		10			3,545	24
25	BJC - Bike rink			1978	2,500		5			2,500	25
26	BJC - Air conditioning system			1979	22,876		10			22,876	26
27	BJC - Site improvement			1979	1,440		26			1,187	27
28	Roof			1979	12,166		10			12,166	28
29	Roofing			1986	45,811		10			45,811	29
30	Remodeling			1988	46,656		10			46,656	30
31	Water line			1989	3,166		20			1,820	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Tank removal	1991	$ 9,809	$	10	$ 981	$ 981	$ 9,400	37
38	Parking lot	1992	10,452		10	1,045	1,045	8,972	38
39	Paint restrooms	1992	230		5			230	39
40	Boiler room remodeling	1993	15,106		20	755	755	6,049	40
41	Repave parking lot	1994	850		10	85	85	574	41
42	Pump	1994	734		10	73	73	526	42
43	Air conditioner work	1994	943		10	94	94	668	43
44	Boiler room project	1994	170,330		20	8,517	8,517	58,406	44
45	Land improvement - trees	1996	3,470		20	174	174	839	45
46	BJC - improvements	1998	15,712		30	524	524	1,746	46
47	Water line repair	1999	3,102		10	310	310	543	47
48	Land improvement - trees	1999	25,849		20	1,292	1,292	2,369	48
49	Gate	1999	550		5	110	110	183	49
50	Floor	2000	1,683		7	240	240	281	50
51	Remodeling	1999	5,773		10	577	577	914	51
52	Total Life Center	1998	122,261		30	4,075	4,075	12,566	52
53	Leasehold improvements	1985	15,200		10			15,200	53
54	Leasehold improvements	1986	19,507		10			19,507	54
55	Painting	1987	9,922		3			9,922	55
56	Steel door	1987	6,020		10			6,020	56
57	Window replacement	1987	2,013		10			2,013	57
58	Generator switch	1988	3,335		10			3,335	58
59	Remodel lobby	1989	156,996	5,233	30	5,233	(0)	55,385	59
60	Bus hut	1989	4,715	314	15	314		3,353	60
61	Water heater	1989	6,721		10			6,721	61
62	Transfer switch	1989	1,127		10			1,127	62
63	Heat-energy panel	1989	8,633		10			8,633	63
64	Leasehold improvements	1989	6,629	77	10	77	(0)	888	64
65	Roof repair	1990	6,928		10			6,928	65
66	Remodeling	1990	6,953	232	30	232		2,588	66
67	Overhead door	1990	1,220		10			1,220	67
68	Kitchen tanks	1990	3,089		10			3,089	68
69	Plastering	1990	2,586	8	10	8		2,586	69
70	TOTAL (lines 4 thru 69)		$ 4,595,965	$ 5,864		$ 145,903	$ 140,039	$ 1,903,939	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,595,965	$ 5,864		$ 145,903	$ 140,039	$ 1,903,939	1
2	Remodel ceiling	1990	2,970	25	10	25		2,970	2
3	Leasehold improvements	1990	26,015	97	10	97		26,015	3
4	Leasehold improvements	1991	2,141	88	10	88		2,119	4
5	Window replacement	1992	2,750	275	10	275		2,544	5
6	Cafeteria doors	1993	11,918	1,192	10	1,192		9,733	6
7	Plumbing work	1994	6,858	686	10	686		4,800	7
8	Painting	1995	3,076	308	10	308		1,846	8
9	Wall and door repair	1995	2,596	260	10	260		1,558	9
10	Door	1996	656	66	10	66		328	10
11	Roof repair	1996	5,985	598	10	598		2,992	11
12	Furnace	1996	502	50	10	50		251	12
13	Land improvements	1996	1,385		3			1,385	13
14	Repairs	1996	10,702	2,038	5	2,038		10,188	14
15	Grip caps	1996	1,575	315	5	315		1,575	15
16	Boiler	1996	3,335	334	10	334		1,668	16
17	Bedding	1996	1,505		3			1,505	17
18	Air deflectors	1996	381		3			381	18
19	Shower	1996	259	52	5	52		259	19
20	Remodeling	1996	4,928	493	10	493		2,464	20
21	Roof repair	1997	798	80	10	80		319	21
22	Drapes	1997	4,500	900	5	900		3,600	22
23	Floor coverings	1997	1,722	172	10	172		689	23
24	Drapes - Life Center	1997	3,153	631	5	631		2,522	24
25	Floor coverings - Life Center	1997	4,422	442	10	442		1,769	25
26	Painting - Life Center	1997	8,917	892	10	892		3,567	26
27	Floor	1997	2,658		10				27
28	Alarms/smoke detectors	1998	20,108	4,022	5	4,022		9,750	28
29	Snack lounge - remodeling	1999	2,847	569	5	569		1,329	29
30	Roof repairs	1999	846	85	10	85		190	30
31	Carpet in front office	1999	8,881	1,776	5	1,776		3,848	31
32	Yard signs	1999	2,825	283	10	283		589	32
33	New tees & valves	1999	11,685	1,169	10	1,169		2,434	33
34	TOTAL (lines 1 thru 33)		$ 4,758,864	$ 23,759		$ 163,800	$ 140,039	$ 2,009,127	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,758,864	$ 23,759		$ 163,800	$ 140,039	$ 2,009,127	1
2	Vinyl wall covering	1999	1,127	113	10	113		225	2
3	Shower room repairs	1999	8,220	822	10	822		1,644	3
4	Connection fees for sewer project	1998	7,438	744	10	744		1,921	4
5	Tree removal	1999	9,857	986	10	986		1,807	5
6	Condenser	1999	12,396	1,240	10	1,240		2,273	6
7	Leasehold improvements	1999	2,598	520	5	520		952	7
8	Landscaping	1999	18,255	1,826	10	1,826		3,118	8
9	Drop rod assembly	1999	6,408	641	10	641		1,121	9
10	Fencing	1999	3,840	384	10	384		640	10
11	Trees	1999	9,905	991	10	991		1,568	11
12	Roof repairs	2000	2,300	230	10	230		307	12
13	Tile floor - resident wing	2000	34,740	3,474	10	3,474		4,632	13
14	Painting	2000	6,352	1,270	5	1,270		1,588	14
15	Window replacement	2000	2,009	201	10	201		251	15
16	Leasehold improvements	1999	5,754	1,151	5	1,151		1,574	16
17	Cabinet modification	1999	4,520	646	7	646		969	17
18	Holy Cross - Electrical	1999	17,410	1,161	15	1,161		2,321	18
19	Holy Cross - Sign	1999	900	180	5	180		360	19
20	Holy Cross - Masonry	1999	23,465	1,564	15	1,564		3,129	20
21	Holy Cross - Plumbing/Heating	1999	31,000	2,067	15	2,067		4,133	21
22	Holy Cross - Remodeling	1999	19,524	1,302	15	1,302		2,603	22
23	Sewage plant	1990	6,411	321		321		3,259	23
24	Painting	1996	1,620					1,620	24
25	Sewer project	1996	9,387	939		939		4,694	25
26	Kitchen Appliances	2000	774	142		142		142	26
27	Washers	2000	19,580	2,545		2,545		2,545	27
28	Freezers	2000	11,752	1,596	20	1,596		1,596	28
29	Furniture	2000	217	36	3	36		36	29
30	Lawnmower	2000	450	68	10	68		68	30
31	2 T.V.'s	2000	1,399	210		210		210	31
32	Heavy Duty Slicer	2000	2,325	310		310		310	32
33	Beds	2000	18,037	2,405		2,405		2,405	33
34	TOTAL (lines 1 thru 33)		$ 4,986,882	$ 45,269		$ 185,310	$ 140,039	$ 2,046,264	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,986,882	$ 45,269		$ 185,310	$ 140,039	$ 2,046,264	1
2	Pump in Boiler Room	2001	2,457	82		82		82	2
3	Parking Lot Stripes	2000	1,549	284		284		284	3
4	Painting Ceiling of Basement	2000	664	66		66		66	4
5	Computers	2000	14,394	4,121		4,121		4,121	5
6	5 Desks	2000	1,326	199		199		199	6
7	Computer Equipment	2000	797	177		177		177	7
8	Computer	2001	2,319	241		241		241	8
9	Printer	2001	1,128						9
10	Wheelchair Lift	2000	13,547	1,806		1,806		1,806	10
11	2000 Isuzu Truck	2000	8,941	894		894		894	11
12	Irpovement	1979	1,440	55		55	55	1,242	12
13	Sewage treatment plan	1989	3,166	158		158	158	1,979	13
14	Tank removal	1990	6,411	323		323	323	3,579	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,045,021	$ 53,675		$ 193,716	$ 140,575	$ 2,060,935	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,540,505	$ 94,134	$ 94,134	$		$ 342,070	71
72	Current Year Purchases	76,955	7,394	7,394			7,394	72
73	Fully Depreciated Assets	697,585	17,945	17,945			697,585	73
74								74
75	TOTALS	$ 2,315,045	$ 119,473	$ 119,473	$		$ 1,047,049	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Resident	Trucks	Various	$ 84,895	$ 10,869	$ 10,869	$	5	$ 42,367	76
77	Transportation	Vans (& wheelchair lift)	Various	34,424	1,806	1,806		5	22,683	77
78		Cars	Various	39,323	7,865	7,865		5	28,764	78
79										79
80	TOTALS			$ 158,642	$ 20,540	$ 20,540	$		$ 93,814	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,518,709	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 193,688	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 333,729	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 140,575	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,201,798	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Franciscan Brothers of the Holy Cross (related party)
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 1975
    Ending 2011

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/30/2002	$ 270,000
13.	6/30/2003	$ 270,000
14.	6/30/2004	$ 270,000

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ NONE Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 1,980	$	$ 1,980
2	Books and Supplies		248		248
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		2,773		2,773
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 5,001	$	$ 5,001
10	SUM OF line 9, col. 1 and 2 (e)	$ 5,001			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,340,306	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	548,352		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,773		6
7	Other Prepaid Expenses	6,613		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,903,044	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	665,732		15
16	Equipment, at Historical Cost	1,666,086		16
17	Accumulated Depreciation (book methods)	(1,444,721)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 887,097	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,790,141	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,764	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	63,734		30
31	Accrued Taxes Payable (excluding real estate taxes)	37,107		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued vacation	44,325		36
37	Other (miscellaneous)	1,625		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 150,555	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 150,555	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,639,586	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,790,141	$	48

***(See instructions.)**

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,289,198	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,289,198	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	350,388	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 350,388	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,639,586	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,336,413	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,336,413	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	14,900	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,472	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 20,372	23
	D. Non-Operating Revenue		
24	Contributions	111,143	24
25	Interest and Other Investment Income***	102,939	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 214,082	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Micellaneous Income**	1,521	28
28a	**Fundraising**	56,033	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 57,554	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,628,421	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	884,072	31
32	Health Care	1,093,083	32
33	General Administration	651,120	33
	B. Capital Expense		
34	Ownership	463,154	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	186,604	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,278,033	40
41	**Income before Income Taxes (line 30 minus line 40)****	350,388	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 350,388	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,842	2,080	$ 45,113	$ 21.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	524	555	10,255	18.48	3
4	Licensed Practical Nurses	11,574	12,523	169,269	13.52	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	3,120	3,120	65,520	21.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,678	28,081	205,946	7.33	15
16	Dishwashers					16
17	Maintenance Workers	5,158	5,577	78,114	14.01	17
18	Housekeepers	5,379	5,854	51,279	8.76	18
19	Laundry	4,438	4,857	51,002	10.50	19
20	Administrator	3,120	3,120	68,560	21.97	20
21	Assistant Administrator					21
22	Other Administrative	223	263	7,878	29.95	22
23	Office Manager					23
24	Clerical	7,430	9,117	140,000	15.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,372	9,927	114,430	11.53	28
29	Resident Services Coordinator	3,120	3,120	65,520	21.00	29
30	Habilitation Aides (DD Homes)	63,460	67,090	608,255	9.07	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	145,438	155,284	$ 1,681,141 *	$ 10.83	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Various	$ 720	1,3	35
36	Medical Director	Various	2,400	9,3	36
37	Medical Records Consultant	Various	280	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Various	1,100	10,3	39
40	Physical Therapy Consultant	Various	38	12,3	40
41	Occupational Therapy Consultant	Various	224	12,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Various	2,420	12,3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Vision	Various	207	10,3	46
47	Medical Visits	Various	2,350	10,3	47
48	Dental Visits	Various	4,755	10,3	48
49	TOTAL (lines 35 - 48)		$ 14,494		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brother Gerald Voychek	Social Services Coordinator		$ 68,560
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 68,560

B. Administrative - Other

Description	Amount
Background Checks	$ 820
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 820

C. Professional Services

Vendor/Payee	Type	Amount
Sikich Gardner & Co, LLP	Acctg, Audit, Technology	$ 10,602
Bank One	Administrative	10,417
Bunn Capital	Administrative	6,510
Sikich Gardner & Co, LLP	Administrative	1,770
Sheehan and Sheehan	Legal	434
Stratton and Giganti	Legal	8,925
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 38,658

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,241
Unemployment Compensation Insurance	9,425
FICA Taxes	102,536
Employee Health Insurance	106,438
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Contribution	37,107
TOTAL (agree to Schedule V, line 22, col.8)	$ 281,747

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NONE		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,791
Health Care Worker Background Check (Indicate # of checks performed)	
Membership Dues	794
Subscriptions	1,990
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,575

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
NONE	
In-State Travel	
NONE	
Seminar Expense	
NONE	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Brother James Court # 0020495 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A

(3) Did the nursing home make political contributions or payments to a politica action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5-7 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 2,120 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 186,604
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ NONE Has any meal income been offset against related costs? NO Indicate the amount. $ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. $ 5,472
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ NONE

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Sikich Gardner & Co, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.